

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. 20021

1- STATE REGISTRAR		2a. DATE KNOWN OF ESTI- MATED MONTH DAY YEAR										2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		<input checked="" type="checkbox"/>		8	16	79	89	M			
Mollie						Boyce											
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
Female		White		Jan 21 1893		86						8 16		79		9P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		U.S.A.				Caroline											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Denton		Andrew Road										Housewife		Home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS									
Maryland		Caroline		Denton				Andrew Road									
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST							
Charles				Collins		Mary											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		221-03-6579		Francis Boyce		Rt2 Box 147 Denton											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. 410- (b) ARTEROSCLEROTIC CARDIOSC DUE DUE TO, OR AS A CONSEQUENCE OF (c) CHROME														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH acute			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Congestive Cardiac Failure / Viral enteritis																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Christian Jensen</i>														TITLE (SPECIFY) M.D. <input checked="" type="checkbox"/> MEDICAL EXAMINER			
EXAMINER'S NAME Christian E. Jensen, M.D. ADDRESS P.O. Box 690 Denton, Md. 21629														DATE SIGNED 8-17-79			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE							
Burial		8/20/79		Gracelawn Cemetery		Wilmington New		Del.									
24. FUNERAL DIRECTOR NAME		ADDRESS		Md. 21629		24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE									
Mr. Charles Moore,		12 S. 2nd St. Denton															
						AUG 20 1979											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILE.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A CEREMONIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												20022							
												REG. NO.							
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED		2b. MONTH DAY YEAR	2d. HOUR		
		Helen I. Cheesman												<input checked="" type="checkbox"/> <input type="checkbox"/>		8-5- 19 79	A M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. MONTH DAY YEAR		7e. HOUR	
Female		Cau.		7-18-09			70 yrs.			MONTHS	DAYS	HOURS	MIN.	8-5-		19 79		1025 A M	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Caroline								
10. CITY OR TOWN OF DEATH Greensboro		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Boyce Mill Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY None											
13a. STATE Md.		13b. COUNTY Caroline		13c. CITY OR TOWN Greensboro			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Boyce Mill Rd.										
14. FATHER'S NAME FIRST Anton Gerth		MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST Erma Eneritz		16. SOCIAL SECURITY NO. 218-10-7909						17. INFORMANT Richard Cheesman		ADDRESS Goldsboro, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) MYOCARDIAL INFARCTION												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE							
410- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC CARDIOVASC. DISEASE CHRONIC							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). PANGINA PECTORIS																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												and in my opinion							
ACTUAL SIGNATURE <i>Christian Jensen MD</i>		TITLE (SPECIFY) M.D. <input checked="" type="checkbox"/>			MEDICAL EXAMINER									DATE SIGNED <i>8/6/79</i>					
EXAMINER'S NAME (TYPE OR PRINT) C.E. JENSEN MD		ADDRESS Box 690, Denton MD 21629																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-8-79			23c. NAME OF CEMETERY OR CREMATORIAL Greensboro			23d. LOCATION CITY OR TOWN Greensboro			COUNTY		STATE						
24. FUNERAL DIRECTOR NAME <i>Joe Bond</i>		ADDRESS Greensboro, Md			25a. DATE REC'D. BY REGISTRAR AUG 10 1979			25b. REGISTRAR'S SIGNATURE <i>Anthony McAleney</i>											

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOURSELF. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 20023				
1- STATE REGISTRAR			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input type="checkbox"/> 8 22 79 11:30									2b. HOUR A M				
1. DECEASED NAME (TYPE OR PRINT)			FIRST OLA			MIDDLE EMMA			LAST DOWNES							
3. SEX F			4. RACE W			5. DATE OF BIRTH MONTH DAY YEAR AUG 4 1895 84			6. AGE (IN YEARS AT BIRTHDAY) YRS.			IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD AUG 22 79		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CAROLINE			MD.				
10. CITY OR TOWN OF DEATH RIDGELY			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS) CROUSE MILL RD									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD			13b. CITY OR TOWN CAROLINE RIDGELY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS							
14. FATHER'S NAME CHARLES F. STARKEY			15. MOTHER'S MAIDEN NAME JULIA WHITBY													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 215-36-1605									17. INFORMANT NORMA LEE DOWNES RIDGELY MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH acute				
(b) Myocardial INFARCTION Arterosclerotic Cardiovasc Disease chronic (c)																
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Cerebrovascular Disease; Senile Dementia																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Christian E. Jensen M.D. X												Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion				
EXAMINER'S NAME (TYPE OR PRINT) CHRISTIAN E. JENSEN MD												TITLE (SPECIFY) MEDICAL EXAMINER				
23a. BURIAL, CREMATION, REMOVAL BASAL			23b. DATE AUG 25 1979			23c. NAME OF CEMETERY OR CREMATORIAL GREENMOUNT			23d. LOCATION CITY OR TOWN HILLSBORO CAROLINE			DATE SIGNED 8/27/79				
24. FUNERAL DIRECTOR MOORE FUNERAL HOME			ADDRESS DENTON MD			25a. DATE REC'D. BY REGISTRAR AUG 30 1979			25b. REGISTRAR'S SIGNATURE mjh							

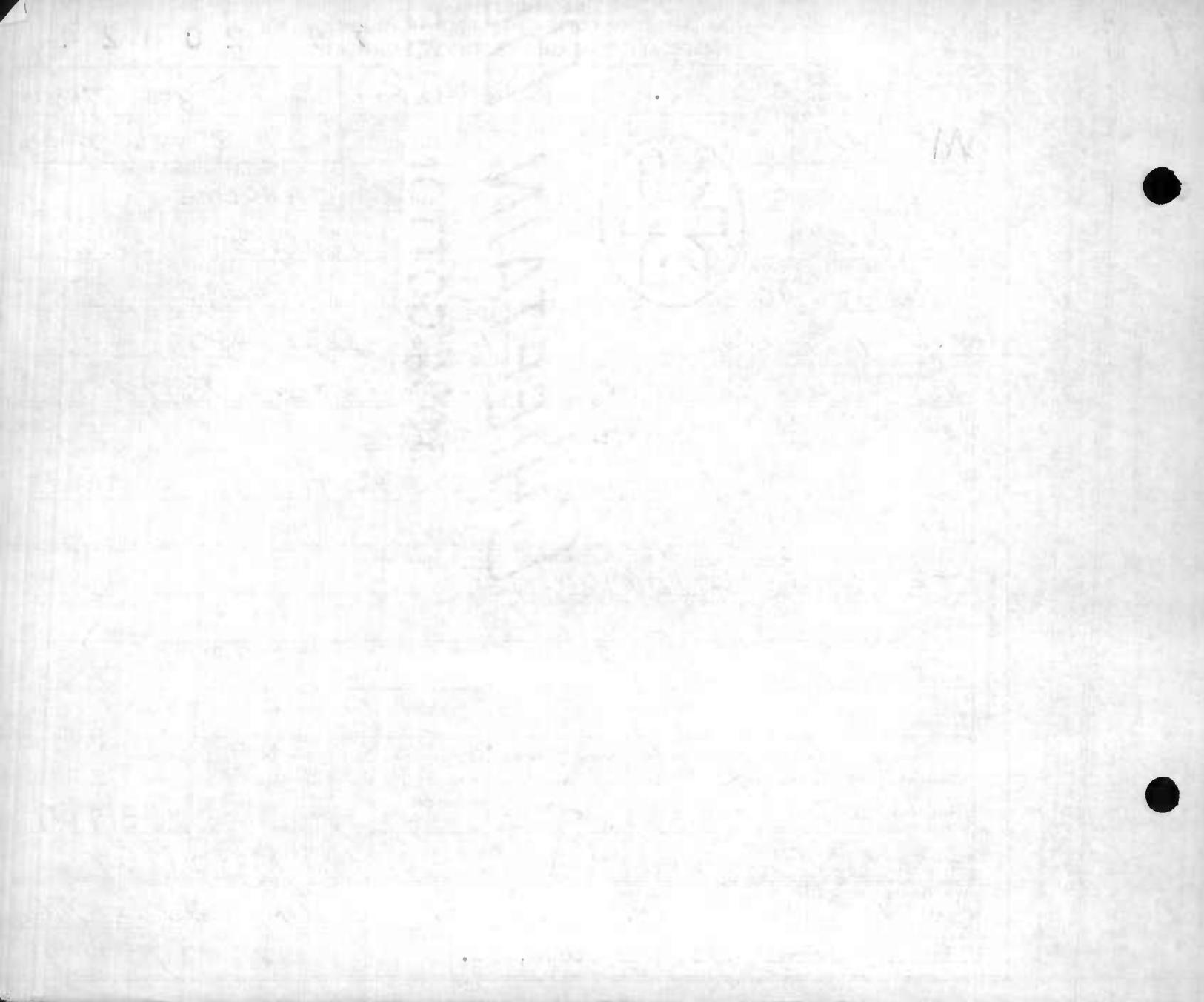


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR RECORDS.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												20024	REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH	DAY	YEAR	2b. HOUR			
JOHN			M.	ESKRIDGE, JR.		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8	5	19	79	5:30			
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD				MONTH	DAY	YEAR	2d. HOUR	
M		W	8 31 26		52	MONTHS	DAYS	HOURS	MIN.	8 5 19 79				6AM		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
MD.			USA					CAROLINE								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY						
PRESTON			MAIN ST			SALES				CHEM.						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS								
MD			CAROLINE		PRESTON	YES <input checked="" type="checkbox"/>		32 MAIN ST.								
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME										
John J. ESKRIDGE, SR.						Ruth Bowmire										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS								
YES			WV 28-20-4622			ELLEN ESKRIDGE, PRESTON										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL RUPTURE</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
410- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>MYOCARDIAL INFARCTION</u>												acute				
(c)												acute				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>PERICARDIAL TAMponADE</u>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> and in my opinion												TITLE (SPECIFY)				
ACTUAL SIGNATURE		<u>Christian E. Jensen</u>										M.D. <input checked="" type="checkbox"/> MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT)		C. E. JENSEN M.D.										ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
BURIAL			8-8-79			MS. VETS. CEM.			BETHESDA, CAROLINE, MD.			CAROLINE		MD.		
24. FUNERAL DIRECTOR			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Ulrich Funeral Home Sharptown, Md.						AUG 13 1979			NOTARY PUBLIC							



Items #18a-22a Film G536 10/11/79 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

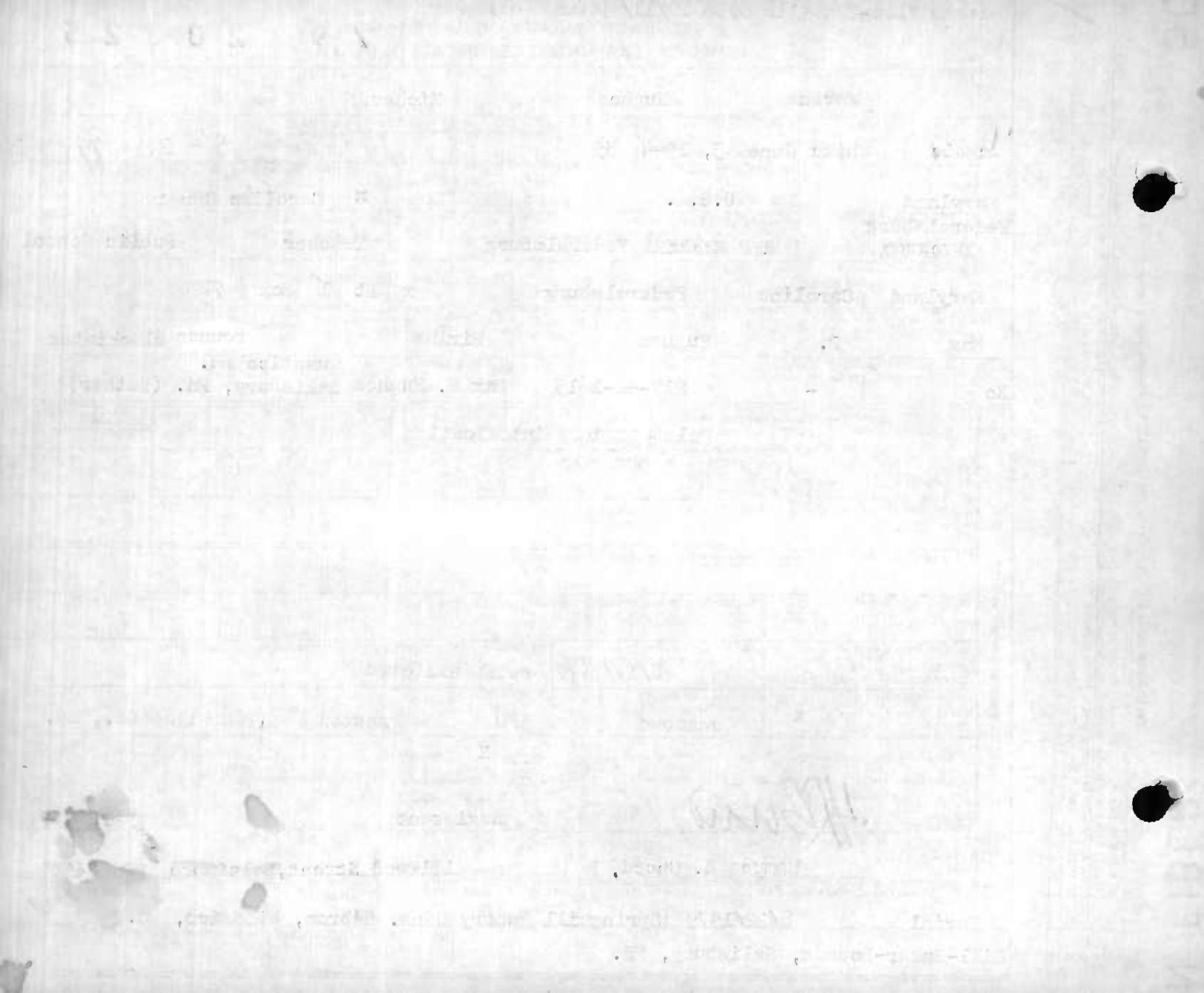
79 20025
REG. NO.

1- STATE REGISTRAR				2a. DATE KNOWN OF ESTI- DEATH MATED				2b. HOUR			
				<input type="checkbox"/> MONTH DAY YEAR				19	M		
I DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST			
Marsha				Hughes				Richards			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
female		white		June 5, 1944		35 yrs.					
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH				10. DATE PRONOUNCED DEAD		11. MEDIUM	
Maryland		U.S.A.		Caroline County				8-20 1979		M	
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				15. KIND OF BUSINESS OR INDUSTRY	
Federalsburg		RFD Hospital Federalsburg				Teacher				Public School	
16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		17. STATE		18. COUNTY		19. CITY OR TOWN		20. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. STREET ADDRESS	
Maryland		Caroline		Federalsburg		Rt #1 Box # 72					
22. FATHER'S NAME		23. MIDDLE		24. LAST		25. MOTHER'S MAIDEN NAME					
Max		P.		Hughes		Miriam					
26. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		27. SOCIAL SECURITY NO.		28. INFORMANT		29. ADDRESS					
No		217-42-1615		Max P. Hughes		Quantico Rd.					
30. DEATH WAS CAUSED BY:		Multiple drug intoxication								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF									
9505 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.		(b)									
		DUE TO, OR AS A CONSEQUENCE OF									
		(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
						<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
7 P.M.		8/19/79		self inflicted							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		CITY OR TOWN		COUNTY STATE	
		unknown		RFD		Preston		Caroline Co., Md.			
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/>		Inspection <input type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion			
death resulted from:		Natural causes <input type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input checked="" type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 8/20/79	
EXAMINER'S NAME (TYPE OR PRINT)		Homrez R. Guard, MD				ADDRESS 111 Penn Street, Baltimore, MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Burial		8/22/1979		Springhill Memory Gdns.		Hebron		Wicomico Co.		Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Hill-Baker-Bounds, Salisbury, Md.						AUG 24 1979					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. ONE PAGE 1/2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 3 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DPMH - 17
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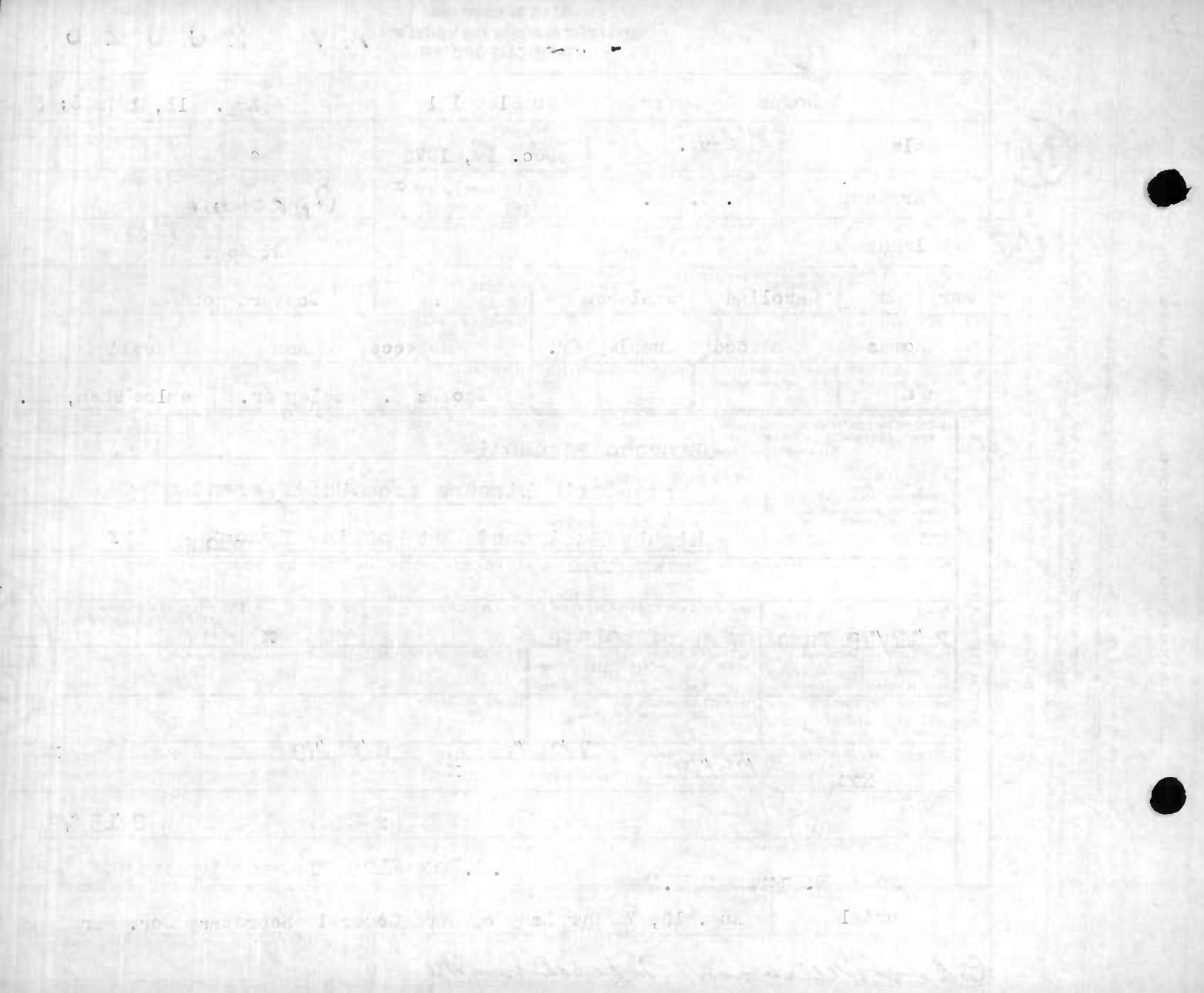
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, an other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						9	20026			
						REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
T homas	Edward	Rumbley	III	Aug.	11,	1979	5:30 M			
3. SEX Male	4. RACE Cau.	5. DATE OF BIRTH MONTH DAY YEAR Dec. 18, 1972		6. AGE (IN YEARS LAST BIRTHDAY) 6 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE COUNTRY Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CAROLINE MD.						
10. CITY OR TOWN OF DEATH Bethlehem	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) None				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland	13b. COUNTY Caroline	13c. CITY OR TOWN Bethlehem	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Tanyard Road					
14. FATHER'S NAME FIRST Thomas	MIDDLE Edward	LAST Rumbley Jr.	15. MOTHER'S MAIDEN NAME FIRST Rebecca		MIDDLE Ann	LAST Koski				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) n/a	16b. SOCIAL SECURITY NO.	17. INFORMANT Thomas E. Rumbley Jr.		ADDRESS Bethlehem, Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia										
2028 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) Metastatic Disease from Undifferentiated				
{ DUE TO, OR AS A CONSEQUENCE OF (c) highly Malignant Non Hogkins Lymphoma						1 lyr				
DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION 2/17/79 Tumor	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED mass of palate				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/26/79, 19 8/11/79, 19, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 7/26/79, 19, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.										
22b. SIGNATURE H. B. Plummer						DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	DATE SIGNED 8/15/79
22c. PHYSICIAN'S NAME (TYPE OR PRINT)	22d. ADDRESS P.O. Box #129 Preston Md 21655									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Aug. 13, 79	23c. NAME OF CEMETERY OR CREMATORIAL Our Lady of Good Counsel				23d. LOCATION CITY OR TOWN Secretary Dor.	COUNTY	STATE Maryland		
24. FUNERAL DIRECTOR NAME Edna Williamson	ADDRESS Federating, Md.	25a. DATE REC'D. BY REGISTRAR AUG 21 1979				25b. REGISTRAR'S SIGNATURE				

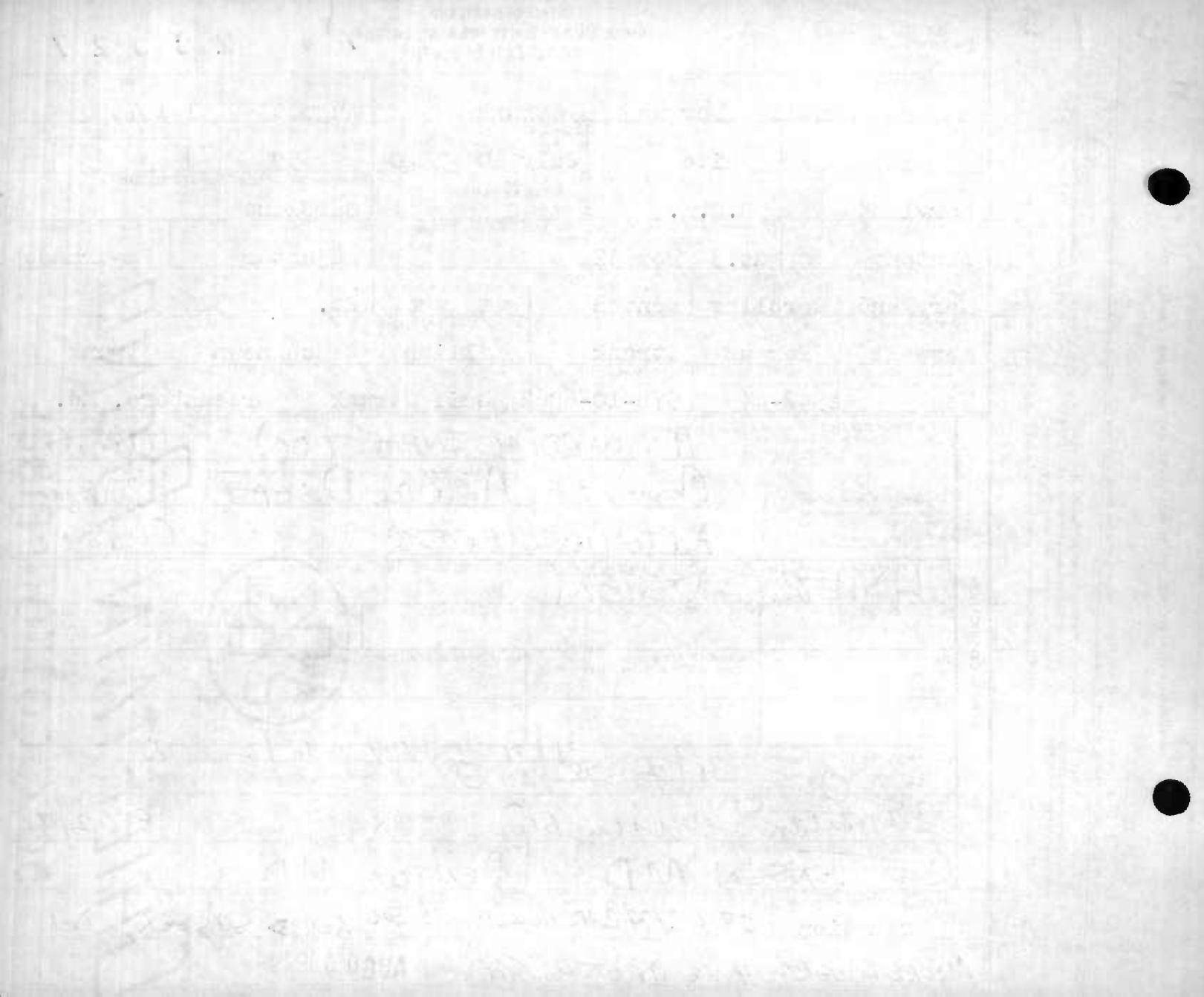


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.					
1. FOR STATE REGISTRAR			2a. FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			Maxwell Fergus			Strunk						August	1	1979	M		
3. SEX			4. RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			White			MONTH DAY YEAR						59	YRS.	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			U.S.A.									Caroline MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Denton			Rt. 3 Box 32A			Adjuster			Insurance								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
Maryland			Caroline			Denton						Rt. 3 Box 32A					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
Maxwell Fergus Strunk			Lillian			1942-44			Gail Strunk			Greensboro, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												acute					
(b) DUE TO, OR AS A CONSEQUENCE OF Coronary Artery Disease												chronic					
(c) DUE TO, OR AS A CONSEQUENCE OF Arteriosclerosis												chronic					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																	
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) this hospital attended the deceased from now the deceased died on 11/2 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (otherwise we did not view the body after death)			22b. DEGREE			22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 8/02/77								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
C.E. JENSEN MD			DENTON MD														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 08/10/79			23c. NAME OF CEMETERY OR CREMATORY CAPE亨lopen F.H., Inc.			23d. LOCATION CITY OR TOWN Lewis			COUNTY SUSSEX		STAFF Det.			
24. FUNERAL DIRECTOR NAME MOORE FUNERAL HOME			ADDRESS DENTON, Md.			25a. DATE REC'D. BY REGISTRAR AUG 6 1979			25b. REGISTRAR'S SIGNATURE Andy								



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

20028

1. DECEASED NAME (Type or print)	First MARY	Middle J.	Last TURNER	2a. DATE OF DEATH Month Aug Day 12 Year 1979	2b. HOUR 11 AM			
3. SEX Female	4. RACE Cau.	5. DATE OF BIRTH 3-28-07		6. AGE (In years lost birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Caroline					
10. CITY OR TOWN OF DEATH Denton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Caroline Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Caroline	13c. CITY OR TOWN Henderson	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER None				
14. FATHER'S NAME First Robert E. Jones	Middle	Last	15. MOTHER'S MAIDEN NAME First Katie Urry	Middle	Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16b. SOCIAL SECURITY NO. 216-18-8814	17. INFORMANT Delma Baynard	Address Greensboro, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH acute	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS; CEREBROARTERIOSCLEROSIS								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from 3/23/79 , to 8/12/79 , that (I) (we) last saw the deceased alive on 8/1/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							22c. DATE SIGNED 8/13/79	
22b. SIGNATURE Christian E. Jensen MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (Type) CHRISTIAN E. JENSEN MD	22e. ADDRESS DENTON MD 21629							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-15-79	23c. NAME OF CEMETERY OR CREMATORIAL Greensboro	23d. LOCATION (City or Town) (County) (State) Greensboro Caroline Md.					
24. FUNERAL DIRECTOR John E. Bowles Greensboro	ADDRESS	25a. REGD BY REGISTRAR John E. Bowles	DATE 8/13/79	25b. REGISTRAR'S SIGNATURE John E. Bowles				

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